REALRx

PRIOR AUTHORIZATION REQUEST FORM

GONADOTROPIN RELEASE HORMONE AGONISTS AND ANTAGONISTS

Eligard®, Lupron Depot®, Lupron Depot- Ped®, Orilissa®, Supprelin® LA, Zoladex®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred product is dependent on indication - see below.

Requested Agent: ☐ Eligard® (leuprolide acetate), ☐ Lupron Depot® (leuprolide acetate), ☐ Lupron Depot- Ped® (leuprolide acetate), ☐ Zoladex® (goserelin), ☐ Orilissa 200mg tablets (elagolix)

Non-Preferred Agents: ☐ Supprelin® LA (histrelin)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the requested medication being purchased by the provider's office and to be billed under the medical benefit ('buy-and-bill')?	☐	☐	
2. Is this request for an expedited review? By checking the "Yes" box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
ADVANCED BREAST CANCER			
3. Does the member have a diagnosis of advanced breast cancer?	☐	☐	**Please provide documentation**
4. Is the member ≥18 years of age?	☐	☐	
5. Is the prescriber an oncologist or endocrinologist?	☐	☐	
6. Is the request for the preferred product Zoladex®?	☐	☐	
CENTRAL PRECOCIOUS PUBERTY			
1. Does the member have a diagnosis of central precocious puberty?	☐	☐	

2. Is the prescriber a pediatric endocrinologist?	☐	☐	
3. Does documentation show baseline LH levels and a LH concentration after GnRH stimulation test?	☐	☐	**Please provide documentation**
4. Does documentation show a baseline LH/FSH ratio and a LH/FSH ratio after GnRH stimulation test?	☐	☐	**Please provide documentation**
5. Does documentation show the member's baseline bone age is 1 year greater than chronological age?	☐	☐	**Please provide documentation**
6. Does documentation include the member's age at onset of secondary sexual characteristics?	☐	☐	**Please provide documentation**
7. Does documentation show the member's Tanner Stage is ≥ 2?	☐	☐	**Please provide documentation**
8. Have the following diagnoses been ruled out? • Adrenal steroid levels for congenital adrenal hyperplasia • Beta human chorionic gonadotropin level for chorionic gonadotropin secreting tumor • Pelvic/adrenal/testicular ultrasound for steroid secreting tumor • CT scan of head to rule out intracranial tumor	☐	☐	**Please provide documentation**
9. Is the request for the preferred product Lupron Depot-Ped®?	☐	☐	
ENDOMETRIOSIS			
1. For endometriosis with inadequate pain control, is the request for the preferred product Lupron Depot® or Zoladex®? **Imaging confirming the diagnosis is required.**	☐	☐	**Please provide documentation**
2. For endometriosis with dyspareunia and inadequate pain control, is the request for Orilissa® 200mg? **Imaging confirming the diagnosis is required.**	☐	☐	**Please provide documentation**
3. Is the requesting provider an OB/GYN?	☐	☐	
4. Does documentation show a negative pregnancy test?	☐	☐	**Please provide documentation**
5. Has the member tried and failed at least two of the following: • A combination (estrogen-progesterone) contraceptive taken continuously • A progestin such as DepoProvera® (medroxyprogesterone), Nexplanon® (etonogestrel) or Mirena® (levonorgestrel) • Danazol	☐	☐	**Please provide documentation**
ENDOMETRIAL THINNING			
1. Is the member ≥18 years of age?	☐	☐	
2. Is the requesting provider an OB/GYN?	☐	☐	
3. Is the requested therapy for dysfunctional uterine bleeding prior to endometrial ablation?	☐	☐	**Please provide documentation**
4. Is the request for the preferred product Zoladex®?	☐	☐	
PROSTATE CANCER			
1. Is the member ≥ 18 years of age?	☐	☐	
2. Is the requesting prescriber an oncologist or endocrinologist?	☐	☐	
3. Is the request for the preferred product Eligard®?	☐	☐	
UTERINE LEIOMYOMATA			
1. Is the request for the preferred product Lupron Depot®?	☐	☐	**If yes, please complete questions 2 to 4**

2. Is the member ≥ 18 years of age?	☐	☐	
3. Does the member have a diagnosis of uterine leiomyomata requiring option of surgical intervention?	☐	☐	**Please provide documentation**
4. Does documentation show a clinical estimation of the size of uterus or fibroids?	☐	☐	**Please provide documentation**
5. Is the request for Oriahnn®?	☐	☐	**If yes, complete questions 6 to 11**
6. Is the prescribing provider an OB/GYN, or in consultation with one?	☐	☐	
7. Has the member tried and failed Lupron Depot® AND at least one of the following therapies unless contraindicated? • Combined estrogen-progestin contraceptive • Levonorgestrel-releasing intrauterine systems • Tranexamic acid	☐	☐	**Please provide documentation**
8. Does the member have a clinical diagnosis of uterine leiomyomata (fibroid) as shown by ultrasound?	☐	☐	**Please provide documentation**
9. Does the member have a negative pregnancy test?	☐	☐	**Please provide documentation**
10. Has an endometrial biopsy been performed to rule out endometrial cancer?	☐	☐	**Please provide documentation**
11. Does the member have a t-score > -2.0 at the lumbar spine, total hip, and femoral neck?	☐	☐	**Please provide documentation**
ADOLESCENT GENDER DYSPHORIA			
1. **For Utah Members Only – see PHARM-150 Hormone Therapy for Gender Dysphoria**			
2. Is the member <18 years of age?	☐	☐	
3. Is the member's Tanner Score ≥ 2?	☐	☐	**Please provide documentation**
4. Has the member been evaluated by a mental health specialist or a provider that is specialized in this treatment area?	☐	☐	**Please provide documentation**
5. Does the member have a pervasive and intense pattern of gender non-conformity or gender dysphoria?	☐	☐	**Please provide documentation**
6. Have co-existing psychological, medical, or social problems that could interfere with treatment been addressed?	☐	☐	
7. Has the member given informed consent and have the parents/legal guardian provided signed consent to treatment and will they be involved in the treatment process?	☐	☐	**Please provide documentation**
8. Is the request for the preferred product Eligard®?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
Breast Cancer			
1. Does the member have a continued medical need for therapy?	☐	☐	**Please provide documentation**
2. Has the therapy been effective and tolerable?	☐	☐	**Please provide documentation**
CENTRAL PRECOCIOUS PUBERTY			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show suppression of increasing LH and FSH levels from baseline?	☐	☐	**Please provide documentation**
3. Has the member's height velocity slowed or stabilized from baseline?	☐	☐	**Please provide documentation**
4. Has the member's bone age slowed from baseline?	☐	☐	**Please provide documentation**

5. Is there a stabilization or regression of the member's Tanner Staging?	☐	☐	**Please provide documentation**
6. Is the member ≤12 years of age if female or ≤13 years of age if male?	☐	☐	
ENDOMETRIOSIS			
1. Does the member have a recurrence of symptoms?	☐	☐	**Please provide documentation**
2. Is the request for Lupron Depot® (leuprolide) or Zoladex® (goserelin) AND has the member received < 12 months of therapy?	☐	☐	**Please provide documentation**
PROSTATE CANCER			
1. Does the member have a continued medical need for therapy?	☐	☐	**Please provide documentation**
2. Has the therapy been effective and tolerable?	☐	☐	**Please provide documentation**
UTERINE LEIOMYOMATA			
1. Does the member have a continued medical need for therapy?	☐	☐	**Please provide documentation**
2. Is the request for Oriahnn® AND has the member received < 24 months of therapy months of therapy?	☐	☐	**Please provide documentation**
ADOLESCENT GENDER DYSPHORIA			
For Utah Members Only – see PHARM-150 Hormone Therapy for Gender Dysphoria			
1. Is the member <18 years of age?	☐	☐	
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy: PHARM-026
Origination Date: 07/31/2018
Reviewed/Revised Date: 07/31/2023
Next Review Date: 07/31/2024
Current Effective Date: 08/01/2023